

STATE OF MICHIGAN
IN THE SUPREME COURT

MICHIGAN CHIROPRACTIC
COUNCIL and the MICHIGAN
CHIROPRACTIC SOCIETY,

Petitioners/Appellees,

Supreme Court Nos. 126530, 126531

Court of Appeals Nos. 241870, 241874

Lower Court No. 01-93481-AA

v.

COMMISSIONER OF FINANCIAL
AND INSURANCE SERVICES,

Respondent/Appellant,

And

FARMERS INSURANCE EXCHANGE
and MID-CENTURY INSURANCE COMPANY,

Intervening Respondents/Appellants.

BRIEF OF *AMICUS CURIAE*
INSURANCE INSTITUTE OF MICHIGAN
IN SUPPORT OF APPELLANTS

Respectfully submitted,

WILLINGHAM & COTÉ, P.C.

BY: John A. Yeager (P26756)
Matthew K. Payok (P64776)
Leon J. Letter (P57447)
Attorneys for *Amicus Curiae*
Insurance Institute of Michigan
333 Albert Ave., Ste 500
E. Lansing, MI 48823
(517) 351-6200
Fax: (517) 351-1195

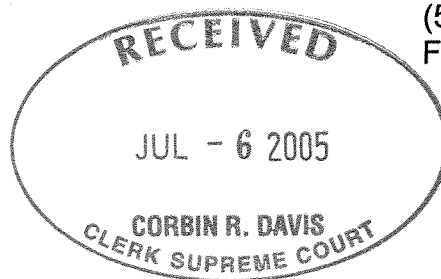


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STATEMENT OF THE BASIS OF JURISDICTION OF THE SUPREME COURT

Amicus curiae Insurance Institute of Michigan states that the Supreme Court has jurisdiction as “[t]he Supreme Court may:... (2) review by appeal a case... after decision of the Court of Appeals.” MCR 7.301. The Court of Appeals issued its decision on August 3, 2004 and this Court granted the Application for Leave to Appeal on May 13, 2005. *Amicus curiae* Insurance Institute of Michigan further accepts and relies on Statement of the Basis of Jurisdiction of the Supreme Court submitted by appellants Farmers Insurance Exchange and Mid-Century Insurance Company (“appellants”) for purposes of this brief.

STATEMENT OF QUESTIONS PRESENTED

1. Whether an optional managed care endorsement such as that offered by intervenors-appellants is permissible under the No-Fault Act, MCL 500.3101, et seq.?

Respondent/ Appellant said:	Yes
Circuit Court said:	No
Court of Appeals said:	No
Intervening Respondents/ Appellants say:	Yes
Amicus Curiae say	Yes

2. Whether the Court of Appeals erred in relying on its finding that the endorsement is potentially deceptive and misleading?

Respondent/ Appellant said:	Yes
Circuit Court said:	No
Court of Appeals said:	No
Intervening Respondents/ Appellants say:	Yes
Amicus Curiae say	Yes

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Amicus curiae Insurance Institute of Michigan accepts and relies on Statement of Facts submitted by appellants for purposes of this brief.

STATEMENT OF INTEREST OF *AMICUS CURIAE* AND GROUNDS SUPPORTING REVERSAL OF THE COURT OF APPEALS' DECISION

The Insurance Institute of Michigan ("IIM") is a non-profit Michigan corporation formed to serve the Michigan insurance industry and insurance consumers as a source of information and education regarding insurance issues for the media, the government, and the public. Its mission includes creating a greater public awareness of the insurance business, and the benefits to the Michigan economy of a private, entrepreneurial insurance and risk management industry through educational and public relations programs, safety and loss prevention activities, strong press and media assistance to consumer programs, legislative and lobbying efforts, judicial and legal overview, and other activities that will promote an improved understanding of the purpose and principles of insurance and assist the public in addressing their business and personal needs. It has 45 insurer members, and most write automobile no-fault policies.¹

¹ The members are: Allied Insurance Company, Allstate Insurance Company, American Fellowship Mutual Insurance Company, Auto Club Insurance Group, Badger Mutual Insurance Company, Cincinnati Insurance Companies, DaimlerCrysler Insurance Company, Elevators Mutual Insurance Company, EMC Insurance Companies, Farm Bureau Insurance Group, Farmers Insurance Group, Farmers & Merchants Mutual Fire Insurance Company, Farmers Mutual Fire Insurance Co., First Non-Profit Insurance Company, Foremost Insurance, Frankenmuth Mutual Insurance Company, Fremont Mutual Insurance Company, GEICO Corporation Group, GMAC Insurance Holdings Group, Grange Insurance Company of Michigan, Great Lakes Casualty Insurance Company, Harleysville Lake States Insurance Company, Hastings Mutual Insurance Company, MEEMIC Insurance Company, Michigan Construction Industrial Mutual, Michigan Insurance Company, Michigan Millers Mutual Insurance Company, Mid-State Surety Corporation, Nationwide Insurance Company, North Pointe Insurance Company, Northern Mutual Insurance Company, Ohio Casualty Group, Pioneer State Mutual Insurance Company, Professionals Direct Insurance Company, Progressive Insurance Company, ProAssurance Insurance Company, Secura Insurance, Southern Michigan Insurance Company, Starr Insurance, State Auto Insurance companies, State Farm Insurance, Titan Insurance company, USAA Group, Westfield Companies and Wolverine Mutual Insurance Company.

IIM's interest is simply this: rising health care costs are a social burden,² and are fast becoming one of the most important political issues in our nation. Hospital billing practices have changed from charging 25% above costs in the 1980's to now be two to four times costs and two to four times what they expect to collect from health insurers and managed care plans. The net effect is that the only way to reasonably purchase health care services is on a group basis.

At the same time, the cost of no-fault insurance, as a component of Michigan's compulsory automobile insurance system, must directly correlate to health care costs under the Essential Insurance Act ("EIA") and, as a result, they rise and fall together. This correlation exists because of the constitutional requirement enunciated by this Court that no-fault insurance be both affordable and available because it is compulsory. The constitutional mandate of maintaining fair and equitable rates is an interest of both policyholders and insurers, since insurers are required to pass on the increasing costs of health care to policyholders under the EIA. As a result, the health care cost shifting has the most damaging effect on those least able to pay, those who do not have health insurance, and thus cannot purchase health care without paying the artificially inflated charges through their no-fault insurance premiums.

Maintaining a stable cost structure is therefore vital to Michigan's compulsory insurance scheme. As a result, developments that help stabilize or maintain costs are

² Citing statistics from the Department of Labor, Bureau of Labor Statistics, the Centers for Medicare & Medicaid Services have reported that health care charges "continued to rise at a faster pace than overall prices"; available at: www.cms.hhs.gov/statistics/health-indicators/analysispart2.asp. Michigan courts have also recognized this problem. See, e.g., *Dean v Auto Club Ins Ass'n*, 139 Mich app 266, 272-273; 362 NW2d 247 (1984).

not only desirable, they are vital. MCL 500.3109a is one such development. It currently allows policyholders who have independent health coverage to choose to coordinate that coverage with their no-fault insurance, which allows the no-fault system to benefit from discounts that health and accident insurers can negotiate on a group basis with health care providers. But no-fault insureds have been unable to obtain these same group discounts, or the discounts that some health care providers allow for worker's compensation and Medicare or Medicaid recipients, in any context other than a § 3109 coordination.

This puts policyholders without independent health and accident coverage at a significant disadvantage. These drivers are charged for health care at a rate higher than the market rate to compensate for the discounts providers give to health insurers.³ And because they cannot choose a § 3109 coordination, they cannot receive the value of group discounts, and inevitably their rates escalate rapidly with the cost of care.

Because of this limitation, the cost of non-coordinated no-fault insurance continues to rise unchecked. Many who do not have or cannot afford health insurance will soon find it difficult to afford no-fault insurance, and the numbers of uninsured drivers will continue to climb. Uninsured drivers skew the entire no-fault system, which is dependent on the participation of all Michigan drivers, and no-fault policyholders eventually pay the costs generated by the uninsured, which are shared throughout the

³ See Exhibit A, Testimony of Dr. Gerard Anderson, Hearing before the House Committee on Energy and Commerce, June 24, 2004, available at: <http://energycommerce.house.gov/108/Hearings/06242004hearing1299/hearing.htm>. Dr. Anderson testifies patients without health insurance inevitably pay for care at higher rates than those who do.

system by the Assigned Claims Facility.⁴ Insurers, who fund the Assigned Claims Facility, also feel the effects of the uninsured. Ultimately, the uninsured impact our entire society with Medicaid claims⁵ when they cannot recover no-fault benefits, making the problem larger still.

As a result, any development that helps stabilize costs and keeps no-fault insurance affordable to everyone benefits policyholders, insurers, and society at large. Appellants' Preferred Provider ("PPO") Endorsement is such a development, allowing drivers without independent health insurance to take advantage of group health care discounts and widening the range of affordable insurance. The Endorsement would help satisfy the constitutional mandates of affordable and available insurance, which is in the interests of both insurers and policyholders. It also is in the interests of the public to minimize the Medicaid costs of the uninsured, who are disqualified from no-fault recovery.⁶

For these reasons, IIM submits that it has the requisite interest in the issues presently before this Court to justify allowing it to express the views which now follow.

⁴ See MCL 500.3171

⁵ *Department of Social Services*, 435 Mich 508; 460 NW2d 194 (1990), and *Depyper v Safeco Ins Co*, 232 Mich App 433; 591 NW2d 344 (1998), both evidence Medicaid payments for injuries suffered in automobile accidents by uninsured drivers. Medicaid then tries to pass the losses back to the insurance system, as it did in these cases. These issues do not arise when drivers are properly insured.

⁶ Owners and registrants of uninsured motor vehicles and motorcycles are disqualified from receiving no fault benefits by MCL 500.3113(b), and then may have a Medicaid claim.

ARGUMENT

I. THIS COURT SHOULD REVERSE THE COURT OF APPEALS DECISION IN THIS CASE, WHICH MISINTERPRETS THE PLAIN LANGUAGE OF THE NO-FAULT ACT, ITS CONSTITUTIONAL REQUIREMENTS, AND ITS ULTIMATE GOALS, ALL OF WHICH SUPPORT APPELLANTS' PPO ENDORSEMENT PROGRAM.

IIM agrees with appellants' contentions that the Court of Appeals decision in this case contradicts *Tousignant v Allstate Ins Co*, 444 Mich 301, 312; 506 NW2d 844 (1993), and that this Court should reverse the Court of Appeals' decision on that basis. But IIM submits that the Court of Appeals decision fails in three other, significant ways. First, the Court ignored the No-Fault Act's plain language and found a nebulous fee-for-service requirement where none existed. Second, the Court ignored the Act's constitutional requirements, including the due process rights of Michigan drivers in the maintenance of a fair and equitable rate structure. Third, the Court ignored the ultimate effect of its decision, which would preclude drivers without health or accident coverage from ever obtaining the advantages of group health insurance discounts. For all these reasons, and those raised by appellants in their Application, IIM recommends that this Court reverse the Court of Appeals' decision.

A. Standard of review.

The resolution of this matter turns on the interpretation of the No-Fault Act. This Court reviews de novo issues of statutory interpretation. *American Federation of State, Co & Municipal Employees v Detroit*, 468 Mich 388, 398; 662 NW2d 695 (2003).

In *Rakestraw v General Dynamics Land Systems, Inc*, 469 Mich 220, 224; 666 NW2d 299 (2003), this Court prescribed the method of analysis for interpreting statutes:

"In interpreting a statute, our obligation is to discern the legislative intent that may reasonably be inferred from the words actually used in the

statute. *White v Ann Arbor*, 406 Mich 554, 562; 281 NW2d 283 (1979). A bedrock principle of statutory construction is that "a clear and unambiguous statute leaves no room for judicial construction or interpretation." *Coleman v Gurwin*, 443 Mich 59, 65; 503 NW2d 435 (1993). When the statutory language is unambiguous, the proper role of the judiciary is to simply apply the terms of the statute to the facts of a particular case. *Turner v Auto Club Ins Ass'n*, 448 Mich 22, 27; 528 NW2d 681 (1995). In addition, words used by the Legislature must be given their common, ordinary meaning. MCL 8.3a."⁷

In addition, a court may consult dictionary definitions to determine the common, ordinary meaning of terms. *Koontz v Ameritech Services, Inc*, 466 Mich 304, 312; 645 NW2d 34 (2002).

B. The PPO Endorsement does not contradict the plain language of the No-Fault Act, and therefore is valid under *Cruz v State Farm Mutual Automobile Ins Co*, 466 Mich 588, 598; 648 NW2d 591 (2002).

The Court of Appeals concluded that the PPO Endorsement "inherently conflicts" with the No-Fault Act, and was invalid as a result. Yet it failed to point to any specific statute or language within the Act that exemplified this "conflict" because none exist. There is nothing in the No-Fault Act that would prohibit insurers from giving policyholders an option to limit the range of their potential health care providers for a reduced premium. Moreover, the Court of Appeals' and appellees' efforts to superimpose a fee-for-service requirement on the No-Fault Act has no support in the statutory text. "Fee-for-service", "range of choice," and "managed care" are merely extra-statutory terms of convenience used to justify the Court of Appeals' decision after the fact.

⁷ For clarity, quotation marks will be placed on block quotations throughout this brief.

1. **The PPO Endorsement is valid under *Cruz* because it does not contradict the plain language of the No-Fault Act.**

In *Cruz v State Farm Mutual Automobile Ins Co*, 466 Mich 588, 598; 648 NW2d 591 (2002), this Court made clear that new developments in no-fault insurance are **“only precluded when they clash with the rules the Legislature has established for such mandatory [no-fault] insurance policies.”** (Emphasis added). Even the Court of Appeals recognized this, but ruled that “a provision that is not in harmony with the no-fault scheme established by the Legislature must be rejected.” *Michigan Chiropractic Council v Insurance Comm’r*, 262 Mich App 228, 239; 685 NW2d 428 (2004).

This is a mischaracterization of *Cruz*. Instead, *Cruz* held that if a provision **“contravenes the requirements of the no-fault act by imposing some greater obligation upon one or another of the parties[, it] is, to that extent, invalid.”** *Cruz*, 466 Mich at 598 (emphasis added). So a provision is only invalid if it contradicts the No-Fault Act, and even then, it is only invalid to the extent of the conflict. The Court of Appeals’ conclusion that the PPO Endorsement was invalid if it was not “in harmony” with the Act, whatever such a nebulous concept might mean, is therefore without support.

Nothing in the No-Fault Act “clashes with” the PPO Endorsement. Neither the Court of Appeals nor appellees were able to cite a single conflict between the Endorsement and any no-fault statute. As a result, they were forced to create an imagined conflict. Over and over, the Court of Appeals noted that the Endorsement was inconsistent with the “most striking feature[s]” of the Act, the “core . . . premise” of the Act, or the “range of choice” provided by the Act. *Michigan Chiropractic Council*, 262

Mich App at 244-246. But these are all extra-statutory concepts that have no basis in the language of the Act itself. The only existing conflict was between the PPO Endorsement and the Court of Appeals' privately-held conception of the No-Fault Act, which is without legal meaning.

This privately-held conception is nothing more than a promotion of the Court's preferred public policy. But the courts' "function is not to redetermine the Legislature's choice or to independently assess what would be most fair or just or best public policy. Our task is to discern the intent of the Legislature from the language of the statute it enacts." *Hanson v Mecosta Co Road Comm'rs*, 465 Mich 492, 504; 638 NW2d 396 (2002). The Court of Appeals' duty was therefore to enforce the Act as written, not to ascribe larger meaning to it.

2. "Fee for service," "managed care," and "range of choice" are all terms of convenience used to justify the imagined conflict.

Both the Court of Appeals and appellees apparently believe that the No-Fault Act creates a "fee for service" system, and that the PPO Endorsement somehow offends the Act's underlying principles by introducing a "managed care" concept that limits choice. But the No-Fault Act says nothing about fee for service requirements, nothing that would indicate a stance on managed care, HMOs, or PPOs, and nothing about choice. These concepts simply do not appear in the Act.

Rather, the Court of Appeals and appellees have superimposed these terms on the Act in order to justify their rejection of the otherwise valid PPO Endorsement. This Court has rejected attempts by litigants and courts alike to inject their own desired language into disputes when it does not comport with the language of the statute or contract:

"We find the language of the policy to be better evidence of what the exclusion excepts from coverage than some **term of convenience** created by litigants, the judiciary, and other members of the legal community to describe the otherwise unnamed, untitled section of such policies." [*Protective Nat'l Ins Co v City of Woodhaven*, 438 Mich 154, 164; 476 NW2d 374 (1991); emphasis added.]

"Fee for service," "managed care," and "range of choice" are all such terms of convenience because they do not exist in the No-Fault Act. MCL 500.3107⁸ fails to

⁸ MCL 500.3107 provides:

(1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except if the injured person requires special or intensive care, or for funeral and burial expenses in the amount set forth in the policy which shall not be less than \$1,750.00 or more than \$5,000.00.

(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for such loss of income shall be reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value shall apply. Beginning March 30, 1973, the benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together shall not exceed \$1,000.00, which maximum shall apply pro rata to any lesser period of work loss. Beginning October 1, 1974, the maximum shall be adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner but any change in the maximum shall apply only to benefits arising out of accidents occurring subsequent to the date of change in the maximum.

(c) Expenses not exceeding \$20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she

endorse, prohibit, or even mention fee-for-service care. Nor does it endorse, prohibit, or even mention managed care, let alone optional managed care. Congress had enacted the Federal Health Maintenance Organizations Act, 42 USC § 300e, in 1973, before the Legislature enacted MCL 500.3109a⁹, so the Legislature certainly could have omitted HMOs from the “other health and accident coverage” mentioned in the latter statute if it intended to prohibit managed care plans that control costs. It did not do so, which reinforces that the No-Fault Act takes no position whatsoever on managed care.¹⁰

had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

(2) A person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b) may waive coverage for work loss benefits by signing a waiver on a form provided by the insurer. An insurer shall offer a reduced premium rate to a person who waives coverage under this subsection for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.

⁹ MCL 500.3109a provides:

An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

¹⁰ To the extent that appellees or their supporters will argue that the referendum on 1993 PA 143 means that No-Fault Act prohibits managed care, they are again wrong. A referendum that strikes down a provision does not somehow enact a statute that is the opposite of the one struck down.

Our Court of Appeals so held in *Reynolds v Martin*, 240 Mich App 84, 97; 610 NW2d 597 (2000):

“[N]othing in the Michigan Constitution suggests that the

MCL 500.3157¹¹ simply states that health care or service providers may charge reasonable amounts and says nothing about how those services are delivered.¹² MCL 500.3107(1)(a) likewise requires coverage for “reasonably necessary” services, and says nothing about how those services are delivered.

There is also nothing in the Act that prohibits policyholders from voluntarily restricting the range of physicians from whom one can seek fully-covered care or services. Since full coverage remains, it is clearly valid under *Cruz*. Moreover, this Court’s decision in *Tousignant* affirmed such a provision in the context of coordinated care, and nothing in the rationale of that decision would preclude its application to the PPO Endorsement. *Tousignant*, 444 Mich at 312-313. The operative factor is the

referendum had a broader effect than nullification of 1994 PA 118. We cannot read into our constitution a general ‘preemption of the field’ that would prevent further legislative action on the issues raised by the referendum.”

So the referendum on 1993 PA 143 simply struck down that Act, nothing more. It had no other effect on the No-Fault Act or on the validity of the managed care concept in the existing statutes.

¹¹ MCL 500.3157 provides:

A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

¹² Although they do not say as much, appellees are essentially arguing that PPOM fees are not reasonable. This is at best disingenuous. Appellees agreed to the PPOM fee schedule outside of the no-fault context, and suddenly the fees are insufficient because the patient has been injured in a car accident instead of falling down a flight of stairs or some other mishap. Do appellees admit that they charge PPOM less than a reasonable fee and then make up for that by over-charging when they treat no-fault policyholders?

policyholder's choice: "The no-fault insured may retain a wide choice of physicians and facilities by not coordinating . . . [but when she chooses coordination], the no-fault insured has, in effect, thereby agreed to relinquish choice of physician and facility." *Id.* at 310.

The same rationale applies to the PPO Endorsement. The policyholder may choose to retain her choice or elect to relinquish that choice for a lower premium. This is not, as the Court of Appeals and appellees assert, an anomaly that only exists in the context of a § 3109a coordination because § 3109a says nothing about choice. The *Tousignant* Court *could have* concluded that § 3109a required no-fault insurers to pay any costs incurred when the policyholder sought treatment outside her health coverage, preserving inviolate the "range of choice" the Court of Appeals so loudly trumpeted in this case. Instead, the *Tousignant* Court concluded that the policyholder could agree to restrict her choice in exchange for a lower premium. The PPO Endorsement offers the same option.

The No Fault Act prescribes *who will pay* when a policyholder suffers injuries in an automobile accident, and prescribes that such payment will be for a "reasonable" amount. It does not prescribe who will provide the care or services. It does not proscribe insurers from offering a lower premium in exchange for restricted choice of who will provide the "reasonably necessary" services covered by MCL 500.3107(1)(a). It does not proscribe policyholders from accepting that offer. Thus, there has been no showing that the PPO Endorsement reduces the coverage required by Section 3107. Both the Court of Appeals and appellees injected their terms of convenience into the Act to create these restrictions, but the Court of Appeals and appellees are not the

Legislature. This Court should therefore reject their attempts to amend the No-Fault Act by judicial fiat and in contravention of this Court's decisions in *Cruz* and *Toussignant*.

C. The PPO Endorsement is consistent with Michigan drivers' due process rights to fair and equitable rates, which this Court has recognized as the paramount concern under the compulsory No-Fault Act.

To the extent that examining the principles underlying the No-Fault Act was proper, the Court of Appeals failed to consider the most important of those principles: the due process rights of Michigan drivers. In *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978), this Court confirmed that the compulsory nature of the No-Fault Act creates a constitutional requirement that no-fault insurance be affordable and available. The PPO Endorsement will help satisfy this requirement and is therefore consistent with the No-Fault Act's goals.

The Legislature created the No-Fault Act pursuant to 1972 PA 294, which became effective March 30, 1973. In the same year, Congress enacted the Health Maintenance Organizations ("HMO") Act of 1973, PL 93-222, effective December 29, 1973. In 1974, the Legislature amended the No-Fault Act to include MCL 500.3109a, requiring insurers to offer motorists with independent health and accident coverage the option to buy no-fault insurance that would remain secondary to that coverage at a lower cost.¹³ So as early as 1974, our Legislature recognized that *any other health coverage*, including HMO coverage, could satisfy no-fault coverage if the insured chose to take advantage of a § 3109a coordination.

¹³ 1974 PA 72.

In June 1978, this Court held that the No-Fault Act's original rate structure was unconstitutional in *Shavers*, 402 Mich at 554. Specifically, the *Shavers* Court concluded that because no-fault insurance was compulsory under the Act, drivers had a due process right that required the state to ensure that such insurance was available at fair and equitable rates:

"In choosing to make no-fault insurance compulsory for all motorists, the Legislature has made the registration and operation of a motor vehicle inexorably dependent on **whether no-fault insurance is available at fair and equitable rates**. Consequently due process protection under the Michigan and United States Constitutions (Const. 1963, Art. 1, § 17; U.S. Const, Am XIV) are operative.

* * *

"We therefore conclude that Michigan motorists are constitutionally entitled to have no-fault insurance made available on a fair and equitable basis. The availability of no-fault insurance and the no-fault insurance rate regulatory scheme are, accordingly, subject to due process scrutiny. [402 Mich 554, 559, 600; emphasis added.]"

The *Shavers* Court gave the Legislature 18 months to create a rate structure that would comply with these requirements. The Legislature responded by amending the Essential Insurance Act ("EIA") to include provisions controlling the rate-making process. 1979 PA 145. MCL 500.2109¹⁴ was the centerpiece of the amendment,

¹⁴ MCL 500.2109 provides:

(1) All rates for automobile insurance and home insurance shall be made in accordance with the following provisions:

(a) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist for the insurance to which the rate is applicable.

(b) A rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is

requiring a direct correlation between health care costs and no-fault insurance rates. This Court reviewed this legislation and concluded that the new rate-making protections satisfied constitutional requirements in *Shavers v Attorney General (Shavers II)*, 412 Mich 1105; 315 NW2d 130 (1982).

Under the EIA, a rate cannot be excessive, inadequate, or unfairly discriminatory. MCL 500.2109(1)(a). An “excessive” rate is “unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist for the

unreasonably low for the insurance provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure that insurance through ordinary methods.

(c) A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss, for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because it reflects differences in expenses for individuals or risks with similar anticipated losses, or because it reflects differences in losses for individuals or risks with similar expenses.

(2) A determination concerning the existence of a reasonable degree of competition with respect to subsection (1)(a) shall take into account a reasonable spectrum of relevant economic tests, including the number of insurers actively engaged in writing the insurance in question, the present availability of such insurance compared to its availability in comparable past periods, the underwriting return of that insurance over a period of time sufficient to assure reliability in relation to the risk associated with that insurance, and the difficulty encountered by new insurers in entering the market in order to compete for the writing of that insurance.

insurance to which the rate is applicable.”¹⁵ An “inadequate” rate is either “unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer,” or “has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants.”¹⁶

The most important requirement for purposes of this case is that a rate cannot be unfairly discriminatory. The net effect is that rates must correlate to costs. Thus, MCL 500.2109(1)(c) provides:

“A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in **losses, expenses, or both**, or by differences in the uncertainty of loss, for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, **in the case of new coverages and classifications, by reasonably anticipated loss and expense experience**. A rate is not unfairly discriminatory because it reflects differences in expenses for individuals or risks with similar anticipated losses, or because it reflects differences for losses for individuals or risks with similar expenses. [Emphasis added.]”

It is important to note that the Legislature expressly contemplated new coverages and classifications in the EIA, and thus it, like this Court’s ruling in *Cruz*, is ample authority for new forms of coverages that satisfy MCL 500.3107(1)(a) by covering reasonably necessary services. However, consistent with this prohibition on discriminatory rates, the Insurance Commissioner determined that the PPO

¹⁵MCL 500.2109(1)(a)

¹⁶MCL 500.2109(b)

Endorsement did not create an artificial cost structure, and that no other group of policyholders would have to effectively pay for this discount:

“This would be a different case if respondent were artificially reducing the cost of the Preferred Provider Option and thereby unfairly shifting the cost of providing benefits to those who elect the standard fee for service no-fault coverage. Persons who elect the fee for service coverage should not be required to subsidize the Preferred Provider Option as a way of forcing policyholders out of the fee for service coverage and into the Preferred Provider Option. In the instant case, there is no evidence that the Preferred Provider Option premium discount is not reasonably calculated to reflect the reduced cost and expenses expected from the program.”¹⁷

It is therefore beyond dispute that the PPO Endorsement complies with the due process requirements that must govern all no-fault rate determinations under *Shavers*.

Because the PPO Endorsement satisfies, and even reinforces, the constitutional requirement of maintaining fair and equitable rates, it should have been nearly impossible for the Court of Appeals to determine that the Endorsement was inconsistent with the No-Fault Act’s goals. The Court achieved this curious result by turning the Act on its head, relying on the dubious “goal” of promoting fee-for-service medicine, instead of the recognized due process requirements, to invalidate the endorsement. Under the Court of Appeals’ analysis, then, constitutional requirements must take a backseat to the No-Fault Act’s strange, unstated preference for paying medical expenses in a “traditional” manner.

As already noted, rising health care costs are at the forefront of our national concerns, and drivers without independent health coverage will feel the most abrupt effect of those costs in their no-fault insurance rates. Yet the Court of Appeals saw fit to

¹⁷ Order Denying In Part Petition for Contested Case Hearing, p 15, attached as Exhibit B.

deny these drivers *the option of selecting* a 40% discount on no-fault insurance premiums, apparently because the Court felt that they could not be trusted to choose in their own best interests.¹⁸ Not only does this decision negate appellants' novel attempt to stabilize costs based on an unstated and previously unrecognized "goal" of the No-Fault Act, it may also impinge the due process rights of Michigan drivers whose only possible method of obtaining health insurers' group discount rates is through the PPO Endorsement. Insurance rates can hardly be fair or equitable when an option exists that would drastically reduce rates for coverages satisfying MCL 500.3107(1)(a), but the state precludes policyholders from choosing that option.

Moreover, even if the promotion of fee-for-service medicine and protecting the due process interest in fair and equitable rates were competing goals of the No-Fault Act, the Court of Appeals was duty-bound to ensure that the Act was first and foremost constitutional. "Whenever possible, [statutory] interpretations that result in constitutional invalidity will be avoided." *Washtenaw County v State Tax Commission*, 422 Mich 346, 371; 373 NW2d 697 (1985). Accord *People v Hayes*, 421 Mich 271, 284; 364 NW2d 635 (1984) ("Whenever possible, courts should construe statutes in such a manner as to render them constitutional."); *Schwartz v Secretary of State*, 393 Mich 42, 50; 222 NW2d 517 (1974) ("Wherever possible an interpretation that does not create constitutional invalidity is preferred to one that does.").

¹⁸ The Court asked "whether consumers, who are prone to overlook the details of their insurance policies, will be lured to accept the PPO option on the basis of the well-publicized forty-percent reduction in their PIP rate, when in fact many will lose significant, and perhaps comparable, premium discounts for the other insurance option or the E-7143, already in place, but which would no longer apply." *Michigan Chiropractic Council*, 262 Mich App at 239-240. The Court of Appeals decision would therefore take that choice away from consumers "for their own good."

- D. The PPO Endorsement is the only available option that allows *all drivers* to take advantage of the health care discounts that are otherwise only available to drivers with independent health and accident coverage. If drivers without health insurance cannot choose such an option, they will have no method of controlling their rates.**

The people getting hurt by the Court of Appeals decision are those least able to pay for insurance, those too poor to afford, or receive as an employment benefit, health and accident insurance they can coordinate with no-fault coverage. The Court of Appeals decision utterly fails to consider its effect on drivers without independent health and accident coverage. In fact, few decisions have considered the real implications of their holdings on drivers, whose rates are dependent on the ultimate costs of the no-fault system. Nevertheless, it is important to realize the effect of rejecting the PPO endorsement on drivers who cannot choose a § 3109a coordination, and who will eventually be required to pay for the discounts received by drivers with independent health coverage pursuant to MCL 500.2109(1)(c).

There is no “free lunch” in the system in light of the EIA’s rate-making requirements. If health-care providers are for-profit entities, they will attempt to make up the profit they lose when they accept group discounts by raising the prices they charge other consumers.

There is a serious problem of cost-shifting in medical billing. Since 1972, when our Legislature adopted the no-fault system, there has been a parallel development of medical cost shifting that ultimately must filter down to those who cannot buy health care on a group basis. The disparity has become particularly egregious. Two references serve to illustrate the problem.

Nortwick v Auto-Owners Ins Co, unpublished opinion per curiam of the Court of Appeals, decided April 15, 2003 (Docket No. 237310) (attached as Exhibit C), provides an example of medical billing practices:

“Plaintiff was injured in a motor vehicle accident and sought personal protection insurance benefits from defendant, her insurer. **She was billed \$225,580.00 by the hospital for medical treatment. The hospital submitted its bill to Medicare, and received \$100,259.47, which it accepted as payment in full for its services.**” (Emphasis added).

Who makes up for this discount in the no-fault context? Those who have non-coordinated no-fault insurance and cannot take advantage of a PPO program such as that before the Court. The second reference (Exhibit A) explains why this phenomena of egregious disparity occurs. As explained by Dr. Gerard Anderson in Congressional testimony on June 24, 2004, major changes in federal medical reimbursements in the 1980s have resulted in “cost shifting and market failure.”

“Without the federal government, state governments, private insurers, or managed care plans paying full charges, the regulatory and market constraints on hospital charges were virtually eliminated. By 1990, the only people paying full charges were the millions of Americans without insurance, a few international visitors and the few people with health savings accounts. These individuals had limited bargaining power and were asked to pay ever increasing prices. Effectively, there was market failure in this aspect of the hospital market.

“Without any market constraints, charges began increasing much faster than costs. **In the mid 1980s charges were typically 25% above costs. Without any market constraints, it is now common for charges to be two to four times higher than costs. Charges are also two to four times what most insurers pay.** Most insurers, including Medicaid, Medicare, and private payors, pay costs plus/minus 15 percent. Over the past twenty years, the difference between what the hospital charges and what it costs to provide care has grown steadily in nearly all hospitals.” (Exhibit A, page 6 or 13, emphasis added).

Thus, the problem *Nortwick* illustrates is not an isolated phenomena. Dr. Anderson’s testimony goes on to explain three main reasons why hospitals set charges

at 2-4 times what they expect to collect from insurers and managed care plans. The first is Medicare “outlier payments,” for patients not within treatment guidelines, which are based on charges: “Recent investigations have shown certain hospital systems manipulating the payment system in inappropriate ways to over charge the Medicare program for outlier patients.” (*Id.*, p 7 of 13). A second reason is to quantify bad debt and charity care to “help with fund raising and is used to meet charitable obligations.” (*Id.*). The third reason is that “some self pay patients actually pay full charges.” (*Id.*).

An ordinary no-fault purchaser who is deprived of a PPO plan such as that before the Court is both deprived of the advantages of a correspondingly lowered premium (mandated by *Shavers* and the EIA), and is subjected to inflated prices. Previous Court of Appeals cases have exacerbated the charging abuses. While cases like *Hofmann v Auto Club Ins Ass’n*, 211 Mich App 55; 535 NW2d 529 (1995), *Mercy Mt Clemens Corp v Auto Club Ins Ass’n*, 219 Mich App 46; 555 NW2d 871 (1996), and *Munson Medical Center v Auto Club Ins Ass’n*, 218 Mich App 375; 554 NW2d 49 (1996), ostensibly only require no-fault insurers to pay the “normal” charges for health care and preclude their use of discounted fee schedules, they actually have a broader effect. They require no-fault insurers to pay the increasingly *inflated* “normal” charges for care that result from other entities’ group discounts, and the insurers then **must** pass those inflated charges down to drivers through the EIA. Thus, the only way for a no-fault purchaser to crack through this facade of systematic inflated billings is either a coordinated policy, or if one cannot afford health insurance, a plan such as is before the Court.

For example, a no-fault insurer cannot currently use a discounted worker’s compensation fee schedule when paying hospital bills. *Munson Medical Center v Auto*

Club Ins Ass'n, 218 Mich App 375; 554 NW2d 49 (1996). Instead, no-fault insurers pay the non-discounted “normal” charges for care. But when other groups, like worker’s compensation insurers or HMOs, are allowed to pay less according to group discounts, “normal” charges will rise to make up for those discounts. In the end, those without the ability to take advantage of group discounts will be required to pay the inflated “normal” costs of charges.

Drivers with independent health and accident coverage can choose a § 3109a coordination, and so can take advantage of their health insurer’s group discounts. This freezes charges to the no-fault insurer, and thus ultimately to the policyholder, at the discounted rate. See, e.g., *Dean v Auto Club Ins Ass’n*, 139 Mich App 266; 362 NW2d 247 (1984). So drivers with independent health coverage can maintain stable no-fault insurance rates if they choose to coordinate because they are able to effectively purchase their medical services on a group basis.

But drivers without independent health and accident coverage have no choice; they must through their no-fault premiums pay the inflated “normal” charges for health care, which is constantly rising, and their rates rise with the aggregate cost of similarly-situated drivers in their risk pool. Ultimately, it is these drivers without independent health and accident coverage who pay the most even though the least likely to be able to afford paying for the “market failure” charges of medical billers.

There are two unavoidable conclusions from this analysis. First, group discounts are the most effective way to control the escalating costs of health care in the no-fault system. Health care providers who allow such discounts to health insurers cannot charge coordinated no-fault insurers for the difference. But without developments like

appellants' PPO Endorsement, drivers without coordinated coverage cannot take advantage of those group discounts.

Second, drivers without health insurance cannot coordinate coverage, and ultimately pay not only the inflated "normal" charges for care to make up for the discounts, but also for all other cost shifting, the aggregate costs of non-automobile medical costs being shifted to the No-Fault system by medical care billing practices. The PPO Endorsement would give these drivers the chance to take themselves out of this cycle of price abuses and to receive the advantages of the PPOM group discount.

If this Court allows the Court of Appeals decision to stand, it will cut off the only option these drivers have to avail themselves of these advantages. So the Court of Appeals decision not only fails as statutory interpretation and constitutional analysis, it also fails as a matter of common sense. The people least able to afford no-fault, those who cannot afford health and accident insurance and do not have the coverage as a fringe benefit, are getting hurt. In light of *Shavers*, and its requirements of equity and affordability, this is irrational.

II. THIS COURT SHOULD REVERSE THE COURT OF APPEALS DECISION IN THIS CASE, WHICH INCORRECTLY DETERMINED THAT THE ENDORSEMENT IS POTENTIALLY DECEPTIVE AND MISLEADING.

IIM agrees with appellant's contention that the declaration language was not potentially deceptive and misleading and that this Court should reverse the Court of Appeals' decision on this basis. After a reading of the whole endorsement, the language therein is not deceptive or misleading.

A. Standard of Review

The resolution of this matter requires this Court to review the language of the endorsement and determine if the language is potentially deceptive and misleading. When construing an insurance contract, a court is required to look at the contract as a whole and give meaning to all terms. *Century Sur. Co. v. Charron*, 230 Mich App 79, 82; 583 NW2d 486 (1998).

B. The endorsement language is not deceptive and misleading and; therefore, is valid.

In creating the PPO Endorsement, attached as Exhibit D, the appellants created various premium reduction options for their insureds to select. Each of these options clearly provides that insureds can select one of the options, E-7143, Other Insurance Rate Credit, or Preferred Provider Option Endorsement, but cannot select multiple options. An insured may not select multiple options but this does not diminish the discounts provided by the option but only prevents insureds from stacking multiple options and their applicable discounts to reduce their P.I.P. premiums.

In making its ruling that the endorsement's language was deceptive and misleading, the Court of Appeals ruled:

"Thus, under Farmers' policies, if a policyholder elects the PPO option, the policyholder forfeits other PIP premium deductions. This "exchange system" of premium discounts renders illusory the touted reduction in the cost of insurance to policyholders. The question arises whether consumers, who are prone to overlook the details of their insurance policies, will be lured to accept the PPO option on the basis of the well-publicized forty-percent reduction in their PIP rate, when in fact many will lose significant, and perhaps comparable, premium discounts for the other insurance option or the E-7143, already in place, but which would no longer apply. This system certainly has the potential for deception--misleading consumers and the public in general. This potential deception provides further basis for reversing the commissioner's decision

pursuant to MCL 500.2029, on the basis of unfair, deceptive, and misleading trade practices.”

Michigan Chiropractic Council v. Insurance Comm’r, 262 Mich App 228, 240-241; 685 NW2d 428 (2004).

However, the Court of Appeals applied the wrong standard when reviewing the endorsement.

When this Court reads the endorsement’s language as a whole to give meaning to all of the language, each of the endorsement’s options clearly states what the applicable discount would be and also clearly states that the other premium reduction options would not be available. Further, contrary to the Court of Appeals’ decision, by selecting the PPO option, the insured is not giving up any preexisting discount as all of the discounts under the endorsement are optional and none apply by default. An insured is not required to select any of the premium reduction options; however, if they choose to do so, the insured can only select one. Although by selecting one of the options the insured loses the other options, the insured, by selecting an option, does not lose a discount that by default the insured had already received.

Therefore, when read as a whole, the language of the endorsement is not misleading or deceiving. Finally, even if the endorsement’s language in this case is suspect, the issue of appropriate language does not diminish the rights of insurers to incorporate the PPO option in their insurance policies and the rights of insureds to select that option.

CONCLUSION AND RELIEF REQUESTED

Based on the above, IIM respectfully requests that this Court reverse the Court of Appeals' decision in this matter. The Court of Appeals' decision contradicts the No-Fault Act, its constitutional underpinnings, and practical logic. The Court of Appeals ignored the No-Fault Act's plain language in favor of its own terms of convenience and public policy. The decision below defeats due process rights of Michigan drivers in the maintenance of a fair and equitable rate structure, which the PPO Endorsement would help protect. Finally, the Court ignored the effect of its decision on Michigan drivers without health or accident coverage, who would never be able to obtain the advantages of group health insurance discounts and would be subject to continually unstable rates. This Court should therefore reverse the Court of Appeals' decision.

Respectfully submitted,

WILLINGHAM & COTÉ, P.C.

Dated: June 29, 2005

BY: _____



John A. Yeager (P26756)
Matthew K. Payok (P64776)
Leon J. Letter (P57447)
Attorneys for *Amicus curiae*
Insurance Institute of Michigan
333 Albert Ave., Ste 500
E. Lansing, MI 48823
(517) 351-6200
Fax: (517) 351-1195

EXHIBIT A



The Committee on Energy and Commerce

Joe Barton, Chairman
U.S. House of Representatives

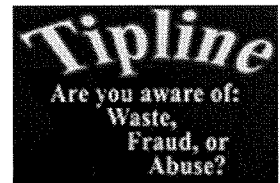
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Witness Testimony

Dr. Gerard Anderson

Professor, Department of Health Policy & Management and International Health, Bloomberg School of Public Health
Johns Hopkins School of Medicine

A Review of Hospital Billing and Collection Practices
Subcommittee on Oversight and Investigations
June 24, 2004
1:30 PM

Mr. Chairman, members of the Committee; my name is Dr. Gerard Anderson. I have been working on hospital payment issues for many years. Between 1978 and 1983, I worked in the Office of the Secretary in the US Department of Health and Human Services. In 1983, I was one of the primary architects of the Medicare Prospective Payment legislation. Following passage of the Medicare Prospective Payment legislation, I joined the faculty at Johns Hopkins where I have been for the past 21 years. At Johns Hopkins, I direct the Johns Hopkins Center for Hospital Finance and Management - the only academically based research center focusing exclusively on hospitals. I am also a professor of Health Policy and Management and professor of International Health in the Bloomberg School of Public Health and Professor of Medicine in the School of Medicine at Johns Hopkins University.

I would like to begin my testimony by highlighting several milestones in hospital payment policy. Because of the evolution of hospital payment policy, self pay patients are currently being charged 2 to 4 times what people with health insurance coverage pay for hospital services. These are not market rates and need to be lower. After reviewing the milestones, I will then make a series of specific suggestions to the committee that will make the current hospital payment system more equitable to the self pay patients. My preferred option is that hospitals be limited to what Medicare pays plus 25 percent.

Critical Milestones That Have Led To Market Failure in Hospital Payment

One hundred years ago most hospital care was either free or very inexpensive. In 1900, hospitals ~~were institutions that~~ could provide little clinical benefit for most illnesses and were primarily places for housing the poor and insane who were sick. Hospitals were primarily philanthropic organizations. They were established primarily in poor urban areas.

Beginning in the 1920s, the ability of hospitals to improve the health status of patients increased dramatically. For the first time, rich and poor Americans sought out hospital care when they became seriously ill. Anesthesia expanded access to surgery and antibiotics made it easier to treat infections.

Physicians had a wider range of services to provide to hospitalized patients. New drugs and new equipment became available and better and more highly trained personnel were required to provide these services. The cost of providing hospital care began to accelerate. In order to recover these higher costs, hospitals began to charge patients for services. Hospitals developed a charge master file. Initially there were only a few items on the list. It listed specific charges for each service the hospital provided. A hospital day had one charge, an hour in the operating room had another charge, and x-ray had a third charge, etc. As the number of services the hospital offered increased, so did the length of the charge master file. There are now over 10,000 items on most hospital charge master files.

Before 1929, there was no health insurance and patients paid the hospital directly. In 1929, Baylor Hospital in Dallas, Texas began a program selling health insurance to school teachers in the Dallas County School district. Baylor created this health insurance system because many of its patients were having difficulty paying hospital bills. It became the prototype Blue Cross Plan. As the depression worsened in the 1930s, the ability of people to pay their hospital bills also worsened. Blue Cross and other types of insurance programs proliferated. These insurers paid charges based upon the charge master file.

During this period, the charges were based on the cost of providing care plus a small allowance for reserves. The markup over costs was typically less than 10%.

Private health insurance received a major boost during World War II when Congress made health insurance tax exempt. After World War II,

private insurers continued to pay the charges that hospitals had established. Over time, ~~the ability of hospitals hospitals ability~~ to improve the health status of their patients increased, the kinds of services provided by hospitals increased and the costs of hospital care began increasing at 2 to 3 times the rate of inflation. By 1960, the typical hospital had established a list of prices for approximately 5,000 separate items. There were no discounts; everyone paid the same rates. The rates that insured and self pay people paid were similar.

Hospitals set their prices for these 5,000 items on a few criteria. ~~on~~ The most important factor was costs. Charges were typically set at a given ~~a~~ markup over costs, usually 10 percent. The hospital would estimate how much it cost to deliver a service and then charge 10% more. The ability of hospitals to estimate cost for individual services, however, was extremely limited by cost accounting. No hospital really knew how much it costs to provide a particular service because cost accounting techniques were not sufficiently detailed.

~~for a very few services change may have been determined by market forces.~~ Market forces determined charges for only a few services. Child birth for example, was one service for which patients could engage in comparative shopping. Pregnant women had almost nine months advance warning that they would be admitted to the hospital and their families could therefore engage in comparative shopping. In theory, they ~~would~~ could compare differences in the out-of-pocket costs and the perceived quality between two hospital delivery rooms, ~~and their perceived quality.~~ Thus, ~~Because of this,~~ hospitals kept delivery room charges at or below actual costs.

For most services, however, it was often impossible for consumers to engage in comparative shopping because ~~either for most services comparative shopping was not possible.~~ Either the admission was an emergency or their doctor had admitting privileges in only one hospital. For most admissions, they had no idea what services they would use during their hospital stay. They could not engage in comparative shopping if they did not know what services they were going to need. In addition, for most people, insurance paid the full bill and so patients had no financial incentive to engage in comparative shopping.

Medicare Becomes Involved

When the Medicare program was established in 1965, Congress decided that the Medicare program would pay hospital costs and not charges. This was the method of payment used primarily by

Blue Cross. Congress recognized that charges were greater than costs and that the Medicare program would be able to exert little control over charges. A very detailed hospital accounting form called the Medicare Cost Report, was created to determine Medicare's allowable costs.

In order to allocate costs between the Medicare program and other payors, the Medicare program required hospitals to collect uniform charge information. Uniform charges were necessary in order to allocate costs to the Medicare program. The Medicare Cost Report could determine allowable costs for the entire hospital, however, it needed a way to allocate these costs specifically to the Medicare program. Charges are used to allocate costs to the Medicare program. If, for example, 40% of the charges were attributed to the Medicare program, then the cost accounting system would allocate 40% of the costs to the Medicare program.

In order to prevent fraud and abuse, the Medicare program required hospitals to establish a uniform set of charges that would apply to everyone. Otherwise, the hospital could allocate charges in such a way that would result in more costs to the Medicare program.

Hospitals continued to have complete discretion on how they established their charges. The Medicare program did not interfere with how hospitals set charges for specific services. One hospital could charge \$5 for an x-ray and another hospital \$25 for the same x-ray. A number of studies conducted at the time showed wide variation in hospital charges.

People with insurance generally had little reason to scrutinize their bills because they had first dollar coverage. Insurance paid the full hospital bill. Also, patients did not know what services they would need and so they did not know what prices to compare. Insurance companies did little to negotiate with hospitals regarding hospital charges in the 1960s and the Medicare and Medicaid programs did not pay on the basis of charges.

In the 1970s, market forces still had a small impact on hospital charges. In reality, the hospital had virtual carte blanche to set the charges. The number of separate items that had a charge associated with them, doubled from 5 to 10,000 at the typical hospital, where it is today.

Two major changes occurred in the 1980s that had a major impact on hospital charges. First, Medicare created the Prospective Payment System which eliminated any need for using hospital charges to allocate hospital costs. Second, most insurers

began negotiating discounts off of charges or using some other mechanism to pay hospitals. As a result, any market forces that existed to limit what hospitals could charge were almost completely eliminated. _

In 1983, the Medicare program moved away from paying costs and instituted the Prospective Payment System (DRGs). As the Medicare Prospective Payment System became operational, the need for the Medicare Cost Report and therefore the need for a uniform charge master file to allocate costs became less and less important. Today, because nearly all of the Medicare program uses some form of prospective payment, the requirement of a uniform charge master file by the Medicare program is virtually unnecessary. _

Managed care plans began to negotiate with hospitals in the early 1980s. They wanted discounts off of charges in return for placing the hospital in their network. They successfully negotiated sizeable discounts with hospitals. As insurers began to compete with managed care plans in the mid 1980s, they also began to move away from paying full charges and started negotiating their own deals. Some insurers decided to pay on a per day basis, others decided to pay discounted charges, or a negotiated rate. Nearly all private insurers and managed care plans stopped using full charges as the basis of payment by 1990. They simply could not compete in the market place if they paid full charges.

Cost Shifting and Market Failure

As each segment of the market developed a different way to pay hospitals, this led to a phenomenon known as "cost shifting". As the Medicare program instituted the Prospective Payment System (DRGs), the Medicare program began to limit the amount that Medicare would spend. Faced with constraints on Medicare (and soon thereafter Medicaid) spending, the hospitals began to engage in "cost shifting".

To do this the hospital industry increased prices to commercial insurers. Given that most commercial contracts were written to reimburse hospitals based on the hospital's own charges, it was a relatively simple matter for hospitals to raise their prices. When commercial insurers tried to raise prices to the employers, however, employers began to examine alternatives. Employers slowly and then rapidly embraced managed care. Managed care expanded rapidly using their market power to negotiate discounts off of charges with hospitals. Soon commercial insurers asked for similar discounts. Private insurers continued to pay more

than Medicare however in most cases.

Without the federal government, state governments, private insurers, or managed care plans paying full charges, the regulatory and market constraints on hospital charges were virtually eliminated. By 1990, the only people paying full charges were the millions of Americans without insurance, a few international visitors and the few people with health savings accounts. These individuals had limited bargaining power and were asked to pay ever increasing prices. Effectively, there was market failure in this aspect of the hospital market.

Without any market constraints, charges began increasing much faster than costs. In the mid 1980s charges were typically 25% above costs. Without any market constraints, it is now common for charges to be two to four times higher than costs. Charges are also two to four times what most insurers pay. Most insurers, including Medicaid, Medicare, and private payors, pay costs plus/minus 15 percent. Over the past twenty years, the difference between what the hospital charges and what it costs to provide care has grown steadily in nearly all hospitals.

Hospitals have been able to increase charges because self pay individuals have limited bargaining power when they enter a hospital. ~~When an uninsured person enters a hospital they have limited bargaining power.~~ They first must find a team of physicians willing to treat them who also have privileges at that hospital. Then they must negotiate with the hospital. Often they wait until they are ill before they seek medical care. This further diminishes their bargaining power because it is now an emergency. Often the hospital wants prepayment. Because most self pay persons have limited resources and cannot make full payment in advance, this further diminishes their bargaining power.

Perhaps the most important constraint on their bargaining power, however, is that they do not know what services they will ultimately need. They do not know how long they will remain in the hospital, what x-rays or lab tests they will need, and therefore they cannot know in advance what services they will require and which of the 10,000 prices they should negotiate.

Costs, and What Insurers Pay in Pennsylvania

Using the most recent data available I compared what insurers pay and what hospitals charge in Pennsylvania. As noted earlier, charges vary considerably from hospital to hospital.

Pennsylvania collects data on what hospitals charge and what insurers pay in Pennsylvania for different illnesses (www.phc4.org). For example, I looked at the charges that Philadelphia area hospitals charged for medical management of a heart attack in 2002. The average charge was over \$30,000. Most insurers paid less than \$10,000.

Why Are Charges So Much Higher Than What Insurers Pay?

— There are three main reasons why hospitals set charges 2-4 times what they expect to collect from insurers and managed care plans. The first is that Medicare outlier payments are partially based on charges. The second is that bad debt and charity care is typically calculated at full charges. The third is that some self pay patients actually pay full charges.

In the Medicare program, a small proportion of patients are much more expensive than the average patient. These are known as outlier patients. Medicare pays for these patients outside of the DRG system. Medicare continues to use charges as part of the formula used to determine outlier payments.

Recent investigations have shown certain hospital systems manipulating the payment system in inappropriate ways to over charge the Medicare program for outlier patients. One aspect of this fraud was the exceptionally high amounts these hospitals charged. Lowering the charges would diminish the over charges in the Medicare program for outlier payments and would reduce the level of fraud.

Second, hospitals routinely quantify the amount of bad debt and charity care they provide. This helps with fund raising and is used to meet charitable obligations. However, by valuing bad debt and charity care at full charges, these numbers vastly over estimate the amount of bad debt and charity care the hospital actually provides.

There are three groups that still pay charges. The first are people who have health savings accounts. Some of these individuals may be able to negotiate discounts although most pay full charges. It is extremely difficult for one person to negotiate with a hospital, especially in an emergency situation. The hospital holds all of the cards. Lowering the charges will benefit people with health savings accounts.

The second category is international visitors. These are typically affluent individuals who need a procedure that can be performed most

effectively in the United States. These individuals are willing to pay full charges, even at inflated prices.

There are compelling arguments to charge international visitors higher prices than Americans. Most can afford to pay and, in addition, they have not subsidized the hospital sector in the United States through tax payments and other public subsidies. On the other hand, in most other countries Americans are usually treated free of charges if they have an emergency. An American injured while traveling in Canada, Australia, France, etc would be treated free of charge or receive a very small bill. Although there is no data that I know of that would allow us to compare the cost of care provided to Americans traveling abroad to the cost of care provided to foreigners receiving care in the U.S., I expect it would be similar. In that case it seems unfair to charge foreign visitors so much more for a service when Americans receive care free of charge overseas.

Impact On The Uninsured

The third, and by far the largest group that is asked to pay full charges is the uninsured. There are 43 million Americans who are uninsured. The uninsured can theoretically negotiate with hospitals over charges, but they have little bargaining power. My review of hospital practices suggests that less than 1 in 20 uninsured patients actually negotiates a lower rate.

Many uninsured people are unable to pay full charges. In fact, most studies suggest that less than 1 in 10 uninsured people pay a portion of their charges and relatively few pay full charges. In fact, in most hospitals only 3 percent of total revenues comes from people who are uninsured. Self pay patients represent a very small proportion of hospital revenues.

The toll on the uninsured, however, can be substantial. There are numerous reports that show hospitals attempting to collect payments from the uninsured. The people who do not pay are sent to collection agencies and some are driven to bankruptcy. One study found that nearly half of all personal bankruptcies were related to medical bills (M.B. Jacoby, T.A. Sullivan, E. Warren, "Rethinking The Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," NYU Law Review 76, May 2001: 375). Another survey (D. Gurewich, R. Seifert, J Pottas, The Consequences of Medical Debt: Evidence From Three Communities, The Access Project, February 2003) found that hospitals were routinely requiring up front payments, refusing to provide care, or encouraging uninsured patients to

seek new providers if they did not have health insurance. Many respondents found the terms the hospitals were offering were difficult to maintain given the hospitals' inflexible collection processes and their own financial situations.

Nearly all hospitals do this to some extent. For example, a series of stories in the Wall Street Journal examined the collection procedures at Yale-New Haven hospital. The Wall Street Journal found that in 2002, the Yale-New Haven hospital was lead plaintiff in 426 civil lawsuits, almost all of which concerned collections or foreclosure lawsuits against individuals, compared with 93 lawsuits at a similarly sized local hospital. Yale-New Haven Hospital also frequently engaged in aggressive collections measures, such as wage garnishment, seizure of bank accounts, and property liens. In 2001, the hospital filed 134 new property liens in New Haven, almost 20 times the number filed by the city's other hospital.

Benefits of Lower Charges

If charges were lowered there could be two beneficial outcomes. First and most important, fewer self pay individuals would declare bankruptcy. Second, more self pay patients would be able to pay their bills if the charges were more in line with prevailing rates.

Guiding Principles for Setting Rates

The question therefore becomes what is a reasonable rate for hospitals to charge self pay patients given that neither market forces or regulations constrain hospital charges.

I propose four guiding principles. First, the rate should not interfere with the market place. The rate that self pay individuals should pay should be greater than what insurers and managed care plans are currently paying hospitals. Second, the charges should not be substantially higher than what insurers and managed care plans are currently paying hospitals. Individuals with limited bargaining power should not be asked to pay exorbitantly high rates because they lack market power. Third, the rate should be transparent to patients. Patients should know the prices they will be asked to pay when they enter the hospital. Fourth, the system should be easy to administer and to monitor.

Two Payment Alternatives

I have two specific suggestions for the Congress to consider.

The first is to mandate that the maximum a patient can pay is the amount paid by Medicare plus 25%. I call this DRG+25%. The rationale for allowing hospitals to charge 25 percent more than Medicare is based on three factors. First, private pay insurers pay an average of 14 percent more than Medicare for a similar patient. I then add one percent for prompt payment. Finally, an additional amount (10%) is added because the amount paid by private insurers is an average and some commercial insurers pay more than the average. Adding the three factors together results in a proposed payment rate of DRG + 25%.

The advantages are that the DRG + 25% rate is easily monitored and adjusts for complexity of the patient. It would be continually updated by Medicare as Medicare updates the PPS rates. The disadvantage is that the rate is not market determined. In most markets, however, it would be above what insurers and managed care plans are paying.

A second option is to allow hospitals to charge the maximum they charge any insurer or managed care plan on a per day basis. The advantage is that it is market determined.

There are four disadvantages. First, it will require regulations and auditing to verify the rate is the maximum they charge any insurer or managed care plan. Second, in order to make the rate transparent, it will be necessary to keep the rate in place for an extended period of time, probably a year. This interferes with the market place. Third, it will require hospitals to tell all insurers and managed care plans who was the worst negotiator. This also interferes with the market place. Fourth, it requires all negotiations to be on a per day basis. Any other payment system would be too complicated. This interferes with the market place.

Balancing the pros and cons of both options, I recommend the DRG+25% option. It complies with all four principles- it is above what insurers are paying, it is a reasonable amount, it is transparent, and it is easy to monitor and verify.

Rate Is Too Low

Insurers may argue that they are entitled to more substantial discounts over self pay individuals for two reasons- prompt payment and volume discounts. The prompt payment argument has some validity. A two month delay in payment at a 6 percent interest rate is equivalent to a 1 percent savings. This is built into the DRG + 25% payment.

The volume discount argument is more complicated. In my opinion it has limited financial impact, especially on medical services. Most insurers and managed care plans do not guarantee a certain volume of patients and certainly they do not guarantee a certain case mix of patients. Instead, they agree to put the hospital on a preferred list of hospitals. The patient and the physician still make the final decision regarding which hospital to select. The choice, therefore is fundamentally different from a purchase in the manufacturing or retail sector where a large volume of goods or services is actually purchased.

The second part of the volume argument, however, is probably more important. The same medical services will be used if the patient is self pay or insured. The patient will use the same set of laboratory tests, spend the same time on the operating table, require the same nursing hours, etc. The medical services are what is most expensive in a hospital and this does not depend on the volume of patients that an insurer has.

Incentives to Purchase Health Insurance

Some individuals with high incomes choose to self insure. An important and difficult question is whether these individuals should be able to get the benefits from these lower rates.

One argument is that these individuals have voluntarily chosen to go without health insurance and they should pay a much higher rate if they get sick. A second argument is that these individuals should be given financial incentives to purchase health insurance and that lowering the hospital rates for them will only induce them to go without coverage.

Although there is merit in both arguments, the question is what is a fair rate for them to pay when they get sick? When they need hospitalization they should pay a rate that is somewhat higher than people with health insurance coverage pay. The DRG +25% criterion meets this objective. This group of people should not be asked to pay for the bad debts of other self pay patients any more than the insured population. And, if the rates were reasonable they would be more likely to pay.

Simplification of Payment System

The medical care system could be simplified if such a change were enacted. One major change would be the elimination of the Medicare Cost Report. A second simplification is that it would be easier to calculate any discounts that hospitals are offering to low income individuals.

The Medicare Cost Report was created in 1965 with the passage of the Medicare legislation and the decision by the Congress to pay costs. The Medicare cost report is now a document that is over 6 inches thick and requires many hours for hospitals to complete. However, with the passage of the Medicare Prospective Payment legislation in 1983 and subsequent adoption of additional Prospective Payment Systems for outpatient care etc., there is no longer a compelling reason for maintaining the Medicare Cost Report. Any information the Congress needs from hospitals to set hospital payment rates could be summarized in a few pages. The only relevant information is the profit of hospitals and some information used to calculate graduate medical education and disproportionate share payments.

Hospitals often give discounts to low income self pay patients. It is therefore key to understand what is the basis for the discount. A discount from full charges is not really a discount if it is still greater than what insurers and managed care plans would pay. A true discount would be below what public and private payors are expected to pay. If the payment system for self pay patients were simplified (DRG + 25%) then it would be easier for them to determine if they are really getting a discount and how much they were expected to pay. Currently the self pay person does not know the real extent of the discount or how much they will pay.

Summary

In summary, what should be done?

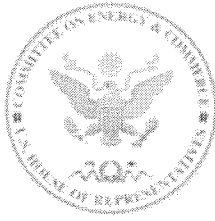
1. Both Congress and the hospital industry should recognize that hospital charges are not determined by market forces. The only people paying full charges are those with limited or no bargaining power.
2. The maximum that self pay individuals should have to pay for hospital services should be DRG rate plus 25%.

I would be happy to answer any questions.

Related Documents

News Release
Subcommittee To Examine How
Hospitals Bill the Uninsured
June 3, 2004

More On CMS/HCFA



The Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515
(202) 225-2927
Contact Us

EXHIBIT B

**STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DIVISION OF INSURANCE**

Before the Commissioner of Financial and Insurance Services

**In the matter of the Petition for
Contested Case filed by the Michigan
Chiropractic Society and the Michigan
Chiropractic Council against Farmers
Insurance Group**

Order No. 01-008-M

**Issued and entered
this 23rd day of January 2001,
by Frank M. Fitzgerald
Commissioner of OFIS**

**ORDER DENYING IN PART
PETITION FOR CONTESTED CASE HEARING**

**I
BACKGROUND**

On August 11, 2000, the Commissioner of the Office of Financial and Insurance Services received a "Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" (the Original Petition) from the Michigan Chiropractic Society and the Michigan Chiropractic Council (collectively, the Petitioners). Petitioners alleged generally that Farmers Insurance Group (the Respondent, or Farmers) was violating the Insurance Code, MCLA 500.100 *et seq*, by offering its policyholders a "Preferred Provider Option Endorsement." Petitioners alleged that this Preferred Provider Option violates the rights of insureds (Count I), violates the rights of medical care providers (Count II), and violates section 3109 of the Insurance Code (Count III). The Original Petition requests that the Commissioner investigate Farmers' policy and practice,

commence an administrative hearing against Farmers under Chapter 20 of the Insurance Code, and disapprove the disputed endorsement under section 2236 of the Insurance Code. The Original Petition also requests that the Commissioner petition the Attorney General's office to bring antitrust charges against Respondent.

Pursuant to Rule 4(1)(b) of the Insurance Bureau hearing rules, AACCS 1983, R. 500.2104(1)(b), the Commissioner, through his staff, requested that Farmers respond to the Original Petition. Farmers filed its "Response by Farmers Insurance Exchange and Mid-Century Insurance Exchange to Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated September 25, 2000. In its Response, Farmers argues that the Preferred Provider Option provides the full range of medical care required by the No-Fault Act, is consistent with the No-Fault Act's goal of providing affordable coverage because policyholders receive a substantial rate reduction for electing this option, and asserts that "numerous Michigan chiropractors have voluntarily agreed to participate, and in fact do participate, as members" of the provider network under the Preferred Provider Option. (Response, ¶¶ 2, 3 and 22) Farmers' Response requests that the Commissioner take no further action on the Original Petition.

The Insurance Division provided Petitioners with a copy of Farmers' Response. Petitioners filed their "Reply in Support of Request for Issuance of Notice of Hearing" dated October 6, 2000. Petitioners argue that the Preferred Provider Option was essentially rejected by voters when Proposal C, a referendum on 1993 PA 143, was defeated. Petitioners acknowledge that 196 chiropractors participate in the preferred provider network, but assert that when they joined, there was no Preferred Provider Option, hence those chiropractors did not agree to participate in the context of no-fault benefits.

The Insurance Division next sent both Petitioners and Respondent requests for additional information. Petitioners responded by filing a "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceeding", dated November 22, 2000, which amended the Original Petition by adding a Count IV. In Count IV they assert that Respondent's refusal to pay for chiropractic care on the grounds that "comparable" non chiropractic care is available through the primary health care coverage constitutes a pattern or practice of violating section 2026 of the Insurance Code.

Farmers also filed an additional response, received on November 30, 2000, asserting that the premium discount for electing the Preferred Provider Option was based on expected reductions in personal injury protection medical expenses and loss adjustment expenses associated with the managed care system. This included an anticipated 25% reduction in the cost of medical services obtained through the provider network, another 15% reduction resulting from utilization management, and unspecified savings from claims review.

II ISSUES

The principal issues are:

1. Should the Commissioner exercise his discretion to commence a contested case hearing based on the assertions of the Original Petition that Respondent's Preferred Provider Option violates the No-Fault Act or the Uniform Trade Practices Act?
2. Should the Commissioner exercise his discretion to commence a contested case hearing based on the assertions of Count IV of the First Amended Petition that Respondent violates the Uniform Trade Practices Act by refusing to pay for chiropractic care under a coordinated no-fault policy where comparable care is available under the primary health care coverage?

III ANALYSIS

The Commissioner has express statutory authority upon probable cause to "examine and investigate into the affairs" of a person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or any unfair or deceptive act or practice prohibited by sections 2001 to 2050 of the Uniform Trade Practices Act. MCLA 500.2028. Where the Commissioner has probable cause to believe that there is or has been such a violation and "that a hearing by the commissioner in respect thereto would be in the interest of the public," he may commence a hearing into the alleged violations. MCLA 500.2029. Moreover, the Commissioner has authority pursuant to section 2236 of the Code to withdraw approval of an insurance policy form that "violates any provisions of this code, or contains inconsistent, ambiguous or misleading clauses, or contains exceptions and condition that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy." MCLA 500.2236(5). Petitioners expressly assert that the Commissioner has jurisdiction in this case (Original Petition, ¶ 1, pg 1; Amended Petition, ¶ 1, pg 1) In its answer, Respondent admits the jurisdictional allegations. (Respondent's answer, ¶ 1, pg 2) Therefore the Commissioner's authority is both well-established and uncontested.

All three counts of the Original Petition challenge the legality of Respondent's Preferred Provider Option. The First Amended Petition repeats the original three counts and adds a Count IV, asserting that Respondent violates section 2026(a) and (n) of the Insurance Code by unjustifiably refusing to pay for chiropractic care where the primary health care coverage provides "comparable" non-chiropractic treatment. Respondent has not yet been given the opportunity to respond to the First Amended Petition. Because

Count IV alleges a separate violation unrelated to the first three counts, except that the Respondent is the same, it is appropriate to deal with Count IV separately. Accordingly, Respondent will be given an opportunity to answer Count IV following entry of this order and the Commissioner will respond to Petitioners' request for a hearing as to Count IV separately at the appropriate time. The analysis that follows applies to the Original Petition for contested case hearing and the first three counts of the First Amended Petition.

The essential facts are not contested. Respondent's Preferred Provider Option allows policyholders to elect to limit their choice of medical care providers in the event they suffer auto related injuries. Policyholders who elect the Preferred Provider Option receive a 40% reduction in the premium for personal injury protection coverage. If they are injured in an automobile accident, policyholders who elect the option must either get their treatment from a network of medical care providers maintained by Preferred Providers of Michigan (PPOM), or, if they go outside the network, they must pay a \$500 deductible and reimbursement is limited to the amount the network pays for the service. Policyholders are not required to select the Preferred Provider Option. They may preserve a broader choice of medical care providers by declining the option and foregoing the premium reduction.

Count I

Petitioners assert in Count I of the Original Petition that the preferred Provider Option violates the rights of insureds because there is no statutory authorization for a managed care option under the No-Fault Act. They also argue that the voters rejected the concept of managed care in the context of the No-Fault Act when they defeated Proposal C, a referendum on 1993 PA 143. Further, they argue that the Preferred

Provider Option has been instituted "in a manner which causes the provision to 'unreasonably or deceptively affect the risk purported to be assumed in the general coverage in the policy', contrary to §2236." (Original Petition, ¶ 17, pg 5)

Respondent answered Count I asserting generally that the Preferred Provider Option is consistent with the legislative purpose of the No-Fault Act, that is, "to provide all reasonably necessary medical care to injured policyholders while at the same time holding down the costs of both medical care and insurance premiums for Michigan insureds." (Farmers' September 25, 2000 Response, pg 2) Farmers denies that the option is prohibited by the No-Fault Act and asserts that:

Insureds receive no different scope or quality of medical care under the Option than they would receive outside the PPOM network. The Option merely defines the universe of providers from whom insureds may obtain medical treatment without having to pay a deductible and fee differential.

(*Id.* ¶ 18, pg 11)

Petitioners have failed to establish that Respondent's Preferred Provider Option is invalid as alleged in Count I of the Original Petition.

First, they have failed to show that statutory authorization is necessary to initiate the Preferred Provider Option. Respondent's Preferred Provider Option is not inherently inconsistent with the requirement of section 3107 that no-fault coverage include "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." MCLA 500.3107(1)(a). Adequate care can be provided through a network of competent providers covering the full range of medical needs. In fact, Respondent asserts that "[i]nsureds receive no different scope or quality of medical care under the Option than they would receive outside the PPOM network." (*Id.*) Respondent acknowledges that

the Option "neither expands nor diminishes the risks purported to be assumed in the general coverage of the policy *because those risks are established as a matter of Michigan law, pursuant to MCLA 500.3107.*" (*Id.* pp 10-11, emphasis added) In short, Respondent recognizes that it is required by statute to provide "all reasonable charges incurred for reasonably necessary" treatment, and asserts that it does so through the PPOM network. Petitioners have provided no evidence that Respondent's claim is untrue.

In an October 24, 2000 letter, the Insurance Division specifically asked Petitioners for evidence that the Preferred Provider Option results in inadequate care as follows:

Are Petitioners alleging that policyholders who elect Farmers' managed care option do not have access to a range of medical care providers within the PPOM network sufficient to adequately provide treatment for automobile related injuries? If so, please provide the Commissioner with a complete description of all of the evidence on which Petitioners rely, including the names of any witnesses, a description of their expected testimony, and copies of any documents supporting the allegation that the network is insufficient.

In response, Petitioners failed to provide any reason to believe that medical treatment available under the PPOM network is inadequate in any regard, arguing instead that "[t]o the extent Insurance Bureau staff has looked towards [Petitioners] to provide detailed evidence, such is unfair." (Memorandum in Support of First Amended Petition, pg 2) On the contrary, it would be unfair to presume that the Preferred Provider Option fails to provide the scope of coverage required by section 3107 based on Petitioners' unsubstantiated allegations. Petitioners' mere allegations, without more, do not rise to the level of probable cause. Moreover, Petitioners recognize that their position "is really straightforward and is based upon legal issues." (*Id.*) Petitioners have failed, both legally and factually, to support their claim that the Preferred Provider Option violates section

3107 and therefore requires statutory authorization.¹

Similarly, the rejection of 1993 PA 143 by referendum does not support Petitioners' argument that the Preferred Provider Option is illegal because it requires express statutory authorization. Petitioners argue that the voters rejected "managed care" in the context of the No-Fault Act when they rejected 1993 PA 143. They also argue that the fact that no-fault insurers sought authorization in 1993 PA 143 for a managed care program demonstrates that they could not initiate a managed care option absent legislative authorization. (Original Petition, ¶¶ 14, 15, and 19) Quite to the contrary, the provision in 1993 PA 143 authorizing "clinical care management" (proposed section 3104b) was only one part of a 48-page proposal that would have changed fundamental aspects of the no-fault system. Among other things, Act 143 would have; (A) allowed policyholders to elect less than unlimited lifetime personal injury protection benefits, (B) required mandatory initial rate reductions of around 16%, (C) required the Commissioner to establish a fee schedule for medical treatment that medical care providers would be required to accept, and (D) imposed additional restrictions on lawsuits. Thus it is mere speculation to conclude that the rejection of 1993 PA 143 was a rejection of the concept of "clinical care management." It could just as easily be argued that the public rejected trading permanent loss of unlimited personal injury protection benefits for a transitory rate reduction.

Moreover, Farmers' Preferred Provider Option is different than Act 143 in another critical aspect. Proposed section 3104b in Act 143 would have allowed no-fault insurers

¹ It is important to emphasize that this would be a different case if there were probable cause to believe that the medical treatment available under the Preferred Provider Option were substandard or that it failed to cover the full range of benefits required by section 3107. However, Respondent expressly acknowledges its statutory obligation to comply with section 3107, and Petitioners have failed to provide any evidence that adequate care is not available.

to impose "clinical care management" upon unwilling policyholders. But Farmers' Preferred Provider endorsement is optional. Policyholders may elect to stay with the existing fee for service arrangement. There is a significant difference between allowing *policyholders to elect* managed care and authorizing *insurers to impose* it on unwilling policyholders. Petitioners argue that the use of managed care under Act 143 was "permissive," because no-fault insurers could choose whether to initiate managed care for an insured whose PIP benefits were not expected to exceed \$250,000. Therefore, they reason, the rejection of Act 143 was a rejection of "all managed care, *especially so-called voluntary managed care because managed care for amounts under \$250,000 was permissive.*" (Reply in Support of Request for Issuance of Notice of Hearing, pg 3, emphasis in the original) Unlike Respondent's plan, Act 143 would have allowed the insurer to decide whether to impose managed care on unwilling policyholders.

Respondent's Preferred Provider Option leaves the choice to the policyholder. In short, contrary to Petitioners' suggestion, PA 143 was more than just a referendum on managed care in no-fault contracts. The rejection of Act 143 does not imply that the Preferred Provider Option is illegal.

The rejection of 1993 PA 143 resulting from the defeat of Proposal C is logically irrelevant to the legality of Respondent's Preferred Provider Option. The question is whether the Preferred Provider Option is inconsistent with the No-Fault Act so that legislative action is necessary before Farmers may offer it. The fact that a very different Act 143 was rejected by the public says nothing useful in answering the question. Petitioners have failed to support their allegation that the Preferred Provider Option is unauthorized and therefore illegal.

Count II

In Count II of the Original Petition, Petitioners argue that the Preferred Provider Option violates the rights of medical providers. More specifically, Petitioners assert that:

PPOM further utilizes practices which exclude from eligibility a vast majority of chiropractors in this state, contrary to the No-Fault Act's requirement that all reasonably necessary expenses be paid, such that the managed care program which adopts PPOM's criteria for network eligibility excludes chiropractic physicians and re-writes the requirements of the No-Fault Act.

(Original Petition, ¶ 23, pg 13) In response, Respondent provided a copy of PPOM's Directory of Chiropractic Care, which discloses that nearly 200 chiropractors participate in the network. Petitioners dismiss the number of chiropractors in the program as "a smattering" and assert that chiropractors who joined the PPOM network did so before Respondent's Preferred Provider Option began, concluding that Respondent "imposed [the Preferred Provider Option] upon its member physicians." (Memorandum in Support of First Amended Petition, pg 2) Somewhat inconsistently, Petitioners also insist that "The sole issue before the Commissioner on complainant's first two counts of its First Amended Petition revolves solely around whether there is any authority for implementing a managed-care scheme under the No-Fault Act." (*Id.*, pg 3)

Petitioners have failed to show probable cause that the Preferred Provider Option violates the rights of medical care providers in general or chiropractors in particular. Policyholders who elect the Preferred Provider Option voluntarily limit their choice of medical care providers to those participating in the PPOM network. Providers who elect to participate in the PPOM network agree to provide their services at rates established by their agreement with PPOM. There is nothing inherently suspect about either of those choices. Under both standard no-fault coverage and the Preferred Provider Option,

policyholders choose their providers. No individual health care provider, regardless of whether he or she participates in the PPOM network, has a right under the No-Fault Act to be paid until an insured chooses that person to provide covered medical care.

Policyholders who elect the Preferred Provider Option have simply agreed to limit their choice to PPOM providers.

Petitioners insist that "providers are entitled to be paid for their 'reasonable and customary charge' and the effect of Farmers' program is to force providers such as chiropractors to either accept a rate less than the customary charge or be excluded completely, both of which are contrary to § 3157 and *Munson Medical Center v Auto Club*, 218 Mich App 375 (1996)." (Original Petition, ¶ 24, pg 7) The Commissioner disagrees. Section 3157 of the Insurance Code authorizes providers "lawfully rendering treatment to an injured person" for an accidental injury covered by personal protection insurance to charge a reasonable amount not to exceed the amount the person or institution customarily charges in cases not involving insurance. MCLA 500.3157. It does not confer a right on any particular provider or class of providers to be chosen to provide care. Similarly, in *Munson Medical Center* the Court of Appeals held that a no-fault insurer is required to pay the "customary charges" of health care providers and could not unilaterally limit payments to the amount that a provider routinely accepts in cases covered by Medicare, Medicaid or Blue Cross Blue Shield. That decision did not establish that medical care providers (A) have a right be selected to provide care under a no-fault policy or (B) could not voluntarily choose to provide care at less than their "customary charge" in exchange for participation in a health care network that may tend to give them access to additional patients.

Petitioners also assert that "[t]his exclusionary practice . . . subjects the policy to

disapproval under §2236 and Chapter 20 for unreasonably and deceptively affecting the risk purportedly assumed." (Original Petition, ¶ 25, pg 6) This allegation is merely conclusory. Petitioners have not presented any authority or separate argument in support of this claim. To the contrary, the underlying theory of the Preferred Provider Option is quite familiar. Health Maintenance Organization subscribers agree generally to limit their choice of providers to those in the network in much the same way that policyholders who elect the Preferred Provider Option agree generally to limit their choice of providers to those in the PPOM network. Petitioners have presented no reason to conclude that the Preferred Provider Option is either unreasonable or deceptive contrary to section 2236.

For these reasons, Petitioners have failed to adequately support their request for a contested case hearing based on the allegations of Count II of the Original Petition.

Count III

Finally, Count III of the Original Petition asserts that Respondent's \$500 deductible for persons who elect the Preferred Provider Option but nevertheless choose providers outside the PPOM network, "is not a deductible, but rather is a penalty." They assert that this violates "both public policy and §3109" and "potentially imposes a tremendous hardship on insureds." (Original Petition, ¶ 27, pg 8) Petitioners also assert that there is sufficient question whether there is a " 'reasonable relationship' between the deductible, the reduced premium and the program under either Sec. 3109 or Sec. 3109a" to require a hearing. (Reply in Support of Request for Issuance of Notice of Hearing, pg 3)

The Insurance Division asked Petitioners to provide specific information to support this accusation. On October 25, 2000 the staff addressed the following question to Petitioners:

Additionally, Petitioners have suggested that there is no reasonable relationship "between the deductible, the reduced premium and the [managed care] program under either Section 3109 or 3109a." Please provide the Commissioner with a complete description of all of the evidence on which Petitioners rely in support of this position, including the names of any witnesses, a description of their expected testimony, and copies of any documents supporting that position.

Petitioners failed to provide any support for their assertion. Instead, Petitioners claimed that the request was "unfair." They claimed that because the Commissioner has exempted insurers from filing no-fault auto policy forms in most cases, they "are in no position to obtain this information." (Memorandum in Support of First Amended Petition, pg 11)

The Insurance Division also asked Respondent for additional information concerning the relationship between the premium reduction and the Preferred Provider Option as follows: "[P]lease describe fully the basis for Farmers' decision to allow a 40% premium reduction for policyholders who elect the managed care option." (October 25, 2000 letter) Farmers responded on November 29, 2000 with the following information:

In structuring the premiums for the PPO Option, Farmers weighed past and prospective loss experience for policyholders selecting the PPO Option, and past and prospective expenses for providing PIP benefits under the program. In particular, Farmers analyzed the expected savings (and associated costs) from participation in managed care. Three components of the program were reviewed: The anticipated reduction in charges for medical services through use of PPOM's network of health care providers; the expected savings associated with the utilization management services provided by Farmers' designated health care review agency (Sloan's Lake), and the savings to be derived from the "usual, customary, and reasonable" bill review services provided by Sloan's Lake.

Based on experience in Colorado, where Farmers had previously introduced a managed care program, as well as assessments provided by administrators seeking to become Farmers' designated health care review agency (including Sloan's Lake), Farmers estimated that approximately one-quarter of its policyholders would elect the PPO Option in the first year. With respect to that policyholder group, Farmers expected, based on

historical data from Colorado and Sloan's Lake, to realize net cost savings in PIP medical expenses of approximately 25%, representing the difference in cost for providing health care services to PIP claimants within as opposed to outside of the managed care program.

Additional savings were anticipated through the utilization management services to be provided by Sloan's Lake. These services monitor treatment to determine appropriateness, use telephonic medical management, and compare proposed treatment to established guidelines. Farmers anticipated an over all PIP cost reduction from utilization management of 15% of the benefits paid to policyholders selecting the PPO Option.

Finally, additional savings were anticipated from the usual, customary, and reasonable bill review services to be provided by Sloan's Lake.

Under section 2109(1) of the Insurance Code, all rates for automobile insurance "shall not be excessive, inadequate, or unfairly discriminatory." A rate is not "excessive" unless it is unreasonably high for the insurance coverage and "a reasonable degree of competition does not exist for the insurance." MCLA 500.2109(1)(a). A rate is not "inadequate" unless it is "unreasonably low" and its continued use either endangers the solvency of the insurer or will have the effect of destroying competition among insurers. MCLA 500.2109(1)(b). In developing and evaluating rates, due consideration shall be given to a number of varied factors including "past and prospective loss experience within and outside this state, . . . to past and prospective expenses, both countrywide and those specially applicable to this state . . . to underwriting practice and judgment; and to all other relevant factors within and outside this state." MCLA 500.2110. Petitioners have presented no reason to believe that Respondent's premium reduction for the Preferred Provider Option violates these statutory standards. Indeed, Respondent's description of the factors supporting the premium reduction suggests compliance with these standards.

Section 3109 of the No-Fault Act authorizes insurers to offer deductibles not exceeding \$300 per accident in exchange for "appropriately reduced premium rates." Other deductible provisions require the approval of the commissioner. MCLA 500.3109(3). On May 31, 2000 the Insurance Division received from Respondent its revised private passenger auto rate filing including the Preferred Provider Option. Respondent defends the \$500 deductible on the grounds that a policyholder who elects the Preferred Provider Option but nevertheless seeks medical care outside the PPOM network "significantly increases the risk and cost to Farmers of treating that insured." (Respondent's answer, ¶ 27, pg 15) Petitioners recognize that fees for care within the network are generally less than a provider's customary charge. (Original Petition, ¶ 24, pg 7) Because treatment outside the network is more expensive and a policyholder who elects the Preferred Provider Option receives a substantial premium discount for agreeing to treat within the PPOM network, there is no basis for objecting to the deductible. A policyholder may avoid it by fulfilling his or her commitment to rely on PPOM providers.

This would be a different case if Respondent were artificially reducing the cost of the Preferred Provider Option and thereby unfairly shifting the cost of providing benefits to those who elect the standard fee for service no-fault coverage. Persons who elect the fee for service coverage should not be required to subsidize the Preferred Provider Option as a way of forcing policyholders out of the fee for service coverage and into the Preferred Provider Option. In the instant case, there is no evidence that the Preferred Provider Option premium discount is not reasonably calculated to reflect the reduced costs and expenses expected from the program.

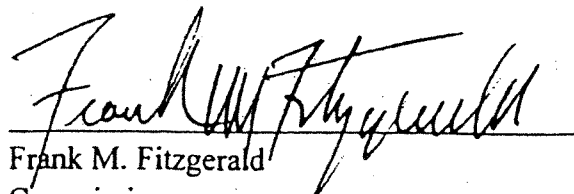
Finally, Petitioners' reliance on section 3109a is misplaced. Section 3109a requires insurers to offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. MCLA 500.3109a. As required by that section, Respondent offers an Other Insurance Rate Credit, which discounts the PIP premium by up to 35% if a policyholder agrees to make his no-fault coverage secondary to other insurance. However, Respondent does not offer the other insurance credit in combination with the Preferred Provider Option, so section 3109a does not apply in the context of the Preferred Provider Option. (Respondent's November 29, 2000 letter; see also Exhibit A to the Original Petition)

Under the circumstances, Petitioners have failed to show probable cause that the Preferred Provider Option violates the Insurance Code as alleged in Court III.

IV ORDER

Therefore, it is ORDERED that:

1. Petitioners' "Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated August 10, 2000 is denied.
2. Petitioners' "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated November 22, 2000 is denied on the grounds stated in Counts I, II, and III.
3. Respondent shall answer Court IV of Petitioners' "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated November 22, 2000 within 30 days from the date of this order pursuant to AACCS 1983, R. 500.2104(1)(b).


Frank M. Fitzgerald
Commissioner
Office of Financial and Insurance Services

**STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DIVISION OF INSURANCE**

Before the Commissioner of Financial and Insurance Services

**In the matter of the Petition for
Contested Case filed by the Michigan
Chiropractic Society and the Michigan
Chiropractic Council against Farmers
Insurance Group**

Order No. 01-017-M

Issued and entered
this 21st day of March 2001,
by Frank M. Fitzgerald
Commissioner of OFIS

ORDER DENYING PETITION FOR CONTESTED CASE HEARING

**I
BACKGROUND**

On August 11, 2000, the Commissioner of the Office of Financial and Insurance Services received a "Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" (the Original Petition) from the Michigan Chiropractic Society and the Michigan Chiropractic Council (collectively, the Petitioners). Petitioners allege generally that Farmers Insurance Group's Preferred Provider Option violates the rights of insureds (Count I), violates the rights of medical care providers (Count II), and violates section 3109 of the Insurance Code (Count III). Petitioners subsequently filed a "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceeding", dated November 22, 2000. This Amended Petition repeats Counts I, II, and III and adds a new Count IV. In Count IV Petitioners assert that Farmers' refusal to pay for chiropractic treatment on the grounds that comparable non chiropractic treatment is available through the primary health coverage violates the no-fault act, MCLA 500.3101 *et seq*,

section 3475 of the Insurance Code, MCLA 500.3475, and Bulletin 90-07 interpreting section 3475.

The Commissioner denied Petitioners' request for a contested case hearing based on Counts I, II, and III by the January 23, 2001 "Order Denying in Part Petition for Contested Case Hearing." The order also required Farmers to respond to Count IV of the Amended Petition pursuant to AACS 1983, R 500.2104(1)(b). Farmers filed its response dated February 22, 2001.

II ISSUE

The principal issue is:

Should the Commissioner exercise his discretion to commence a contested case hearing based on the allegations of Count IV of the Amended Petition that Farmers violates the Insurance Code by refusing to pay for chiropractic care under a no-fault policy that coordinates benefits with other health coverage where comparable non chiropractic care is available through the primary health coverage?

III ANALYSIS

As noted in the January 23, 2001 order, the Commissioner has express statutory authority upon probable cause to investigate and hold a hearing to determine whether a person has been or is engaged in any unfair method of competition or any unfair or deceptive act or practice prohibited by the Uniform Trade Practices Act. MCLA 500.2028 and 500.2029. The Commissioner may, but is not required to, order a contested case hearing in response to Petitioners' request. AACS 1983, R 500.2104. Both parties involved here recognize the Commissioner's authority in this matter.

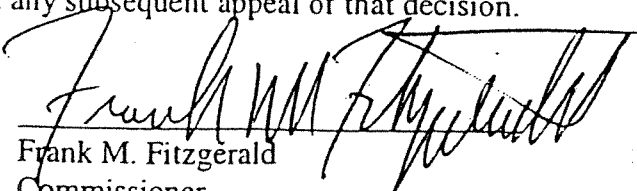
In Count IV of the Amended Petition, Petitioners assert that Farmers violates the Insurance Code by refusing to pay for chiropractic treatment for injuries arising from a covered accident under a coordinated no-fault policy where the primary health coverage provides comparable non chiropractic treatment. In Petitioners' view, a no-fault insurer is required to pay for chiropractic

treatment even though the no-fault policy coordinates benefits with other health coverage that provides appropriate non chiropractic treatment. (Memorandum in Support of First Amended Petition, pp 12-13) Farmers, on the other hand, argues that if competent medical treatment is available to an insured through his primary health coverage, an insured must make reasonable efforts to obtain that treatment before seeking coverage under the coordinated no-fault policy. (Farmers Response to the First Amended Petition, pp 8-9)

The fundamental question of law presented by Count IV is before the Court of Appeals in *Sprague v Farmers Insurance Exchange*, docket no 227400. As a party in that case, Farmers has filed a brief arguing its view of the law. Although Petitioners are not a party in that case, the Court of Appeals allowed them to file an amicus brief opposing Farmers. That case has been fully briefed and is awaiting argument. The Court of Appeals decision in that case may well resolve whether a person covered by a coordinated no-fault policy must first resort to available non chiropractic treatment for a covered accident before seeking chiropractic treatment under the no-fault policy.

IV ORDER

Therefore, it is ORDERED that Petitioners' "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated November 22, 2000 is denied on the grounds stated in Count IV without prejudice. Petitioners may again ask for a contested case hearing on this issue after a final decision in *Sprague v Farmers Insurance Exchange*, Court of Appeals docket no 227400 and any subsequent appeal of that decision.


Frank M. Fitzgerald
Commissioner

Office of Financial and Insurance Services

EXHIBIT C

STATE OF MICHIGAN
COURT OF APPEALS

MARILYN VAN NORTWICK,

Plaintiff-Appellee,

v

AUTO-OWNERS INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED

April 15, 2003

No. 237310

Washtenaw Circuit Court

LC No. 99-005335-NF

Before: Jansen, P.J. and Kelly and Fort Hood, JJ.

PER CURIAM.

Defendant appeals as of right the order granting plaintiff's motion for summary disposition. We reverse. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

Plaintiff was injured in a motor vehicle accident and sought personal protection insurance benefits from defendant, her insurer. She was billed \$225,580.00 by the hospital for medical treatment. The hospital submitted its bill to Medicare, and received \$100,259.47, which it accepted as payment in full for its services. Thereafter, defendant reimbursed Medicare for that amount, as it had primary coverage. The trial court found that plaintiff had incurred the entire expense stated in the hospital's bill, and granted plaintiff judgment for the difference in the amount billed and the amount paid.

This Court will review de novo a trial court's summary disposition ruling. *Smith v Globe Life Ins Co*, 460 Mich 446, 454; 597 NW2d 28 (1999).

The no-fault act contains the following provision regarding the payment of medical expenses:

(1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation....[MCL 500.3107].

In *Shanafelt v Allstate Ins Co*, 217 Mich App 625; 552 NW2d 671 (1996), the plaintiff's medical expenses were paid by her health insurer, and she sought similar payment from her uncoordinated no-fault policy. The defendant argued that plaintiff had not incurred the medical expense where the health insurer had paid the medical bills. The Court found that the term "incur" was not defined in the no-fault statute, and it employed the dictionary definition of incur as meaning "to become liable for." Where the plaintiff became liable for her medical expenses when she accepted treatment, the Court found that the expenses were incurred, without regard to whether she was later compensated by her health insurer.

In *Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001), the Court extended the *Shanafelt* analysis. Employing the *Shanafelt* definition of incur as "to become liable for," the Court found that where a health care provider accepted payment from a health insurer as payment in full, the plaintiff was relieved of any responsibility or legal obligation to pay the providers further amounts. Because the plaintiff bore no liability for the full medical service amounts initially charged by his health care providers, he had not incurred the full charges. *Bombalski*, at 543. An insurer paying benefits under § 3107 need not pay any amount except upon evidence that the services were actually rendered and the actual costs expended. *Id.*

Here, defendant submitted an affidavit from the health care provider indicating that it accepted the Medicare payment as full and final payment of the costs incurred for plaintiff's hospitalization, and it had closed its file on the matter. Where the health care provider accepted the Medicare payment as payment in full, plaintiff had no additional liability and incurred no other expenses.

Reversed and remanded for entry of judgment for defendant. We do not retain jurisdiction.

/s/ Kathleen Jansen
/s/ Kirsten Frank Kelly
/s/ Karen M. Fort Hood

EXHIBIT D

MAJOR AUTOMOBILE COVERAGES

(Continued)

b. Personal Injury Protection (P.I.P.)

This is a mandatory no-fault coverage. P.I.P. provides medical and vocational rehabilitation expenses, lost income, or survivors benefits up to the limits of coverage. Limits and conditions of coverage are specified by the policy and by Michigan State Law. Deductibles and coordination options are available. These benefits apply to the named insured and family members in the household. Occupants of the insured car and pedestrians struck by the insured car are covered only if they don't have their own insurance.

(1) Limits of coverage

The Basic P.I.P. limit provides coverage for qualifying medical expenses up to the limit mandated by law. Presently there is no limit for medical expenses.

(2) The following options will reduce P.I.P. premiums (MCCA assessments are not reduced).

(a) \$300 Deductible P.I.P. (E-7143) —

Policyholders who elect to take the "Endorsement Establishing Deductible and Waiting Period" will receive a 15% reduction from the P.I.P. rates. The endorsement provides a \$300 medical deductible and a 7 day waiting period on benefits for "work loss". (Not available if the other insurance rate credit is taken.)

(b) Other Insurance Rate Credit —

- * P.I.P. rates are discounted 25% if the insured elects their P.I.P. coverage to be secondary over other A & H medical insurance, or another 10% if he elects his weekly indemnity coverage to be secondary to other
- * wage continuation coverage. Thirty Five percent (35%) will be deducted if both coverages are secondary.

These credits are applied to the reduced rate after other credits such as second car discount, etc., have been applied.

If this option is selected, the \$300 deductible credit under the E-7143 described in (a) above will not be allowed.

* (c) Preferred Provider Option Endorsement —

Policyholders who elect the Preferred Provider Endorsement will receive a 40% reduction on their PIP rate. The endorsement requires the insured to choose a physician from our captured network, Preferred Providers of Michigan, to manage health care in the event of a covered injury. The E7143 will not be allowed if this option is selected. The other insurance credit will not be allowed if this option is selected.

All policies in the household are required to carry the PPO option if the insured selects this option. Disclosure form 51-0693 must be signed by the insured for each policy in the household to verify selection of the PPO option.

(d) Unemployed/Low Income Discount — The developed P.I.P. rates are discounted 10% if the principal driver is:

- (1) unemployed, or
- (2) earning less than \$400 monthly.

Note: This discount cannot be combined with the "Waiver of Work Loss Benefits" discount

Farmers Insurance Exchange